Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK HACKBARTH MD
700 OLYMPIC PLAZA SUITE 850
TYLER TX 75701

Respondent Name
NATIONAL SURETY CORP

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-3710-01

MFDR Date Received
JANUARY 12, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "63650 is defined by the CPT Guideline as being 'per array' Often a physician will place 2 arrays in a piggy-back style to give broader coverage (called dual-lead or dual array). This is what Dr. Hackbarth did. Each array was paid on the trial-that EOB is also attached. Per the CPT descriptor I have attached on the next page 'An array defined the collection of contact that are on one catheter,' and per Dr. Hackbarth's op report 2 separate catheters were placed."

Amount in Dispute: $474.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute regarding implantation of neuroelectrodes under CPT Code 63650-59. The date of service is October 1, 2004. Carrier has made appropriate reimbursement under the applicable fee guidelines."

Respondent's Position Summary dated August 22, 2006: "Carrier has previously responded to this dispute on February 23, 3005. Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2004	CPT Code 63650-59	$474.69	$474.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. Former 28 Texas Administrative Code §133.301, effective July 15, 2000, allows insurance carrier's to retrospectively review all complete medical bills and pay for or deny payment for medical benefits in accordance with the Act, rules, and the appropriate Commission fee and treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - C-Negotiated Contract.
   - 255-Based on the available information, this charge does not appear to be applicable in this case.
   - F-Fee schedule MAR reduction.
   - U-Unnecessary treatment (W/O Peer Review).
   - 270-No allowance has been recommended for this procedure/service/supply.

Issues

1. Does a medical necessity issue exist?
2. Does the submitted documentation support a contractual agreement issue exist?
3. Is the requestor entitled to additional reimbursement for CPT code 63650-59?

Findings

1. According to the submitted explanation of benefits, the insurance carrier denied reimbursement for CPT code 63650-59 based upon reason code "U."

   28 Texas Administrative Code §133.301(a) states "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title."

   On June 29, 2004, the provider obtained preauthorization for "Spinal Cord Stimulator Implant." The preauthorization had a start date of June 25, 2004 and end date of August 31, 2004. Although, the surgery was performed after the end date, the medical necessity for the procedure had been determined.

   This is further supported by the respondent payment for one CPT code 63650. The issue in this dispute is lack of payment for the second 63650-59. The Division concludes that a medical necessity issue does not exist in this dispute only a fee issue.

2. The insurance carrier reduced or denied disputed services with reason code "C." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. According to the submitted explanation of benefits, the insurance carrier denied reimbursement for CPT code 63650-59 based upon reason code "255."

   CPT code 63650 is defined as "Percutaneous implantation of neurostimulator electrode array, epidural."

   The requestor used modifier 59 to identify a separate service.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the Operative report indicates that the claimant underwent "Dual spinal cord stimulator lead placement." The Operative report also states that "two separate 14-gauge Tuohy needles were then advanced under fluoroscopic guidance through a left paramedical approach through the previous made wound, one to enter into the T11-12 and the other to the T12-L1 interspace. Upon entering the epidural space, two separate Medtronic Compact Spinal Cord stimulator leads" were used; therefore, the use of modifier -59 is supported.

   The requestor submitted a copy of the explanation of benefits for the trial neurostimulator and the respondent paid for both leads-array The respondent did not submit documentation to support why on the permanent implantation the second lead-array was denied.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the

following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75701, which is located in Smith County.

The Medicare allowable for code 63650 is $379.75

The MAR for CPT code 63650-59 in Smith County is $474.68. The respondent paid $0.00; therefore, the requestor is due $474.68.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $474.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $474.68 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/20/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.